An Information Service of the Division of Medical Assistance

North Carolina

Medicaid Pharmacy

Newsletter

Number 109 *October 2002*

In This Issue...

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Changes in Drug Rebate Manufacturers

The following changes are being made in manufacturers with Drug Rebate Agreements. They are listed by manufacturer code, which is the first five digits of the NDC.

Additions

The following labelers have entered into Drug Rebate Agreements and joined the rebate program effective on the dates indicated below:

Code	*Manufacturer*	*Date*
60553	Trisenox	6/10/2002
64727	Western Research Laboratories	8/20/2002
66302	United Therapeutics Corp.	6/19/2002
66440	Aero Pharmaceuticals, Inc.	8/19/2002
66500	Novavax, Inc.	6/20/2002
66582	MSP Marketing Services, LLC	7/29/2002
66591	aaiPharma	8/12/2002
66594	Pro-Pharma, LLC	8/12/2002
66663	Pharmelle, LLC	7/15/2002
66689	VistaPharm, Inc.	7/17/2002
66758	Parenta Pharmaceuticals, Inc.	5/14/2002
66992	Wraser Pharmaceuticals	7/3/2002
66993	Prasco Laboratories	6/5/2002
67181	Colorado Biolabs, Inc.	6/6/2002
67197	For Ever Young Products, Inc.	7/16/2002
67204	Vindex Pharmaceuticals, Inc.	7/30/2002
67211	Pharmion Corporation	7/23/2002

Terminated Labelers

Zoetica Pharmaceutical Corp. (Labeler Code 64909) is being terminated effective October 1, 2002

The following labeler codes are being voluntarily terminated effective October 1, 2002:

Syntex Laboratories, Inc. (Labeler Code 00033)
Perrigo Company (Labeler Code 00113)
Center Laboratories (Labeler Code 00268)
ParMed Pharmaceuticals (Labeler Code 00349)
Pfizer Pharmaceuticals Group (Labeler Code (00710)
Luitpold Pharmaceuticals (Labeler Code 10797)
Pharmaceutical Ventures, LTD (Labeler Code 50057)
Qualitest Pharmaceuticals, Inc. (Labeler Code 52446)
Praxis Biologics (Labeler Code 53124)
Vintage Pharmaceuticals, LLC (Labeler Code 53404)
SmithKline Beecham Corporation (Labeler Code 57294)
InSource, Inc. (Labeler Code 58441)
Peters Laboratories, Inc. (Labeler Code 58728)
EM Pharma (Labeler Code 63254)

Only the labeler codes indicated will be terminated. Large manufacturers have more than one labeler code.

Federal MAC List Changes

Effective August 1, 2002, the following changes were made to the Medicaid Drug Federal Upper Limit List:

Deletions

Generic Name

Ampicillin/Ampicillin Trihydrate
- 250 mg, Capsule, Oral, 100
- 500 mg, Capsule, Oral, 100

Codeine Phosphate; Promethazine Hydrochloride
- 10 mg/5 ml; 6.25 mg/5 ml, Syrup, Oral, 480 ml

Desipramine Hydrochloride
- 10 mg, Tablet, Oral, 100
- 25 mg, Tablet, Oral, 100
- 50 mg, Tablet, Oral, 100
- 75 mg, Tablet, Oral, 100
- 100 mg, Tablet, Oral, 100

Hydroxyurea
- 500 mg, Capsule, Oral, 100

Hydroxyzine Hydrochloride
- 10 mg, Tablet, Oral, 100
- 25 mg, Tablet, Oral, 100
- 50 mg, Tablet, Oral, 100

Methocarbamol
- 750 mg, Tablet, Oral, 100

Price Increases

Generic Name	New Price
Allopurinol	
300 mg, Tablet, Oral, 100	$0.1671 B
Amantadine Hydrochloride	
100 mg, Capsule, Oral, 100	$0.2463 B
Amitriptyline Hydrochloride	
10 mg, Tablet, Oral, 100	$0.0891 B
25 mg, Tablet, Oral, 100	$0.0936 B
Bumetanide	
1 mg, Tablet, Oral, 100	$0.2348 B
2 mg, Tablet, Oral, 100	$0.4272 B

Providing 72-Hour Emergency Supply

A 72-hour emergency supply should be provided to all recipients who are awaiting the acknowledgment of PA. The pharmacy will be reimbursed for this product even if the prescription is changed to an alternative medication. All claims that are not approved for PA and a 72-hour supply was dispensed should be sent to:

EDS
Attn: Dora De Van
4905 Waters Edge Drive
Raleigh, NC 27606.

If the drug is approved for PA, the emergency supply should be submitted by on-line POS as part of the original fill.

"Medically Necessary" Replaces "Dispense as Written"

Under Section 21.19(h) Dispensing of Generic Drugs---Notwithstanding G.S. 90-85.27 through GS 90-85.31, or any other law to the contrary, under the Medical Assistance Program (Title XIX of the SSA), and except as otherwise provided in this subsection for atypical antipsychotic drugs and drugs listed in the NTI, a prescription order for a drug designated by a trade or brand name shall be considered to be an order for the drug by its established or generic name, except when the prescriber has determined, at the time the drug is prescribed, that the brand name drug is medically necessary and has written on the prescription order the phrase " **MEDICALLY NECESSARY**". An initial prescription order for an atypical antipsychotic drug or a drug listed in the NTI that does not contain the phrase "**MEDICALLY NECESSARY**" shall be considered an order for the drug by its established or generic name, except that a pharmacy shall not substitute a generic or established name prescription drug for subsequent brand or trade name prescription orders of the same prescription drug without explicit oral or written approval of the prescriber given at the time the order is filled.

"Dispense as Written" is no longer valid documentation to override the MAC price.

Health Insurance Portability and Accountability Act Implementation Project Update

N.C. Medicaid's Health Insurance Portability and Accountability Act (HIPAA) implementation project was originally developed to meet the goal of accepting and sending the standard transactions by October 16, 2002, as the first step in meeting full HIPAA compliance. Further analysis of the impact to the Medicaid Management Information System (MMIS) from implementing changes to accommodate HIPAA standard transactions has resulted in the decision to redirect the project.

Federal legislation allows covered entities to apply for a one-year extension. Extending the implementation deadline to October 16, 2003 will allow N.C. Medicaid to complete cost savings initiatives that need to be implemented in the MMIS prior to implementing HIPAA changes.

N.C. Medicaid now plans to implement HIPAA standard transactions, including NCPDP 5.1, by May 1, 2003. **Providers should continue to submit pharmacy claims in the 3.2 format until May 1, 2003.** After May 1, 2003, Medicaid will accept pharmacy claims in the NCPDP 5.1 format. However, N.C. Medicaid will also accept claims received in the NCPDP 3.2 format until October 16, 2003. After October 16, 2003, all claims submitted to N.C. Medicaid, must use NCPDP 5.1.

Once NCPDP 5.1 is implemented, compounds containing all legend products will be accepted on-line POS. Compounds, that require billing of an OTC drug, will need to be submitted on a manual claim form using the current method of billing.

Health Insurance Portability and Accountability Act – Questions and Answers

The Division of Medical Assistance (DMA) is committed to implementing all of the regulations introduced as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This commitment is reflected in the following bulleted mission statement:

- DMA's mission is to comply with HIPAA legislation regarding the use of standard transactions and the replacement of local code sets with national code sets, and
- DMA has deemed that no Medicaid covered services will be eliminated as a result of this legislation, and
- DMA further commits to implementing changes resulting from HIPAA without disruption to the daily operation of the Medicaid program, and
- DMA is likewise committed to implementing the provisions of the Privacy Rule.

DMA also strives to communicate HIPAA information, as it pertains to N.C. Medicaid, to the provider community. In addition to bulletin articles, such as this article on frequently asked questions, information regarding N.C. Medicaid's HIPAA effort may be found on DMA's website at http://www.dhhs.state.nc.us/dma.

General Questions

1. **Who is responsible for training providers about HIPAA?**

Although provider education will be sponsored for North Carolina's Medicaid providers, providers must understand that education will be limited to general HIPAA information and its outcome and effects as it relates to the N.C. Medicaid program only.

Training and information offered by the N.C. Medicaid program does not relieve providers from the responsibility of educating their staff on HIPAA regulations regarding transaction and code set standards and privacy regulations. Providers are encouraged to review the HIPAA rules and discuss required changes with their billing departments, billing agents, and clearinghouses.

2. **How will providers be notified of changes in the N.C. Medicaid program?**

Specific changes implemented by N.C. Medicaid to comply with HIPAA regulations will be published in Medicaid bulletins. The Medicaid bulletin is available online at http://www.dhhs.state.nc.us/dma.

General information about HIPAA, including the federal regulations, implementation deadlines, and transaction standards can be accessed online at http://www.hhs.gov and http://www.cms.gov.

3. **Is there one final rule for health plans and providers?**

Yes. There is one final rule for transactions and code sets. The HIPAA Transaction and Code Set Final Rule, published August 17, 2000 in the Federal Register, applies to all covered entities. The rule (CFR 160 and 162) can be accessed at http://www.access.gpo.gov/su_docs.

4. **What is the compliance deadline for the standard transactions and code sets regulation?**

According to regulation, the deadline to implement the HIPAA electronic transaction and code set standards is October 16, 2002. Federal legislation allows states to apply for one-year extension. N.C. Medicaid now plans to implement HIPAA standard transactions, including NCPDP 5.1, by May 1, 2003. Providers who need to file for an extension should do so before October 16, 2002.

5. **When will the N.C. Medicaid program be HIPAA compliant for electronic transactions and code sets?**

N.C. Medicaid plans to be fully compliant by May 1, 2003. Some transaction sets may be implemented at an earlier date. Please pay close attention to future Medicaid bulletins and to DMA's HIPAA webpage at http://www.dhhs.state.nc.us/dma/prov.htm for additional information.

6. Will HIPAA make claim submittals to other state Medicaid programs easier?

The purpose of the administrative simplification provision of HIPAA is to standardize the electronic data interchange in the health care industry overall. Because there are over 400 different electronic claim formats within the health care industry, HIPAA standards will create a more uniform mechanism for electronic data interchange. However, some health care plans, including Medicaid and Medicare, may still require situational data elements that other health plans do not require. Each health care plan will still direct their policy and billing requirements. Providers should be aware that changes to standardize and promote electronic data interchange may require health plans to also modify the information requirements for paper claims.

7. Will providers be required to submit claims electronically or can we continue to submit paper claims?

Paper claims will continue to be accepted by N.C. Medicaid Pharmacy Program for approved reasons only. A few examples include claims with a billed amount of $10,000 or greater (excluding Botox which has a limit of $1,000 and Synagis which must be submitted either by paper or batch), compounds, or claims that must accompany a diagnosis.

8. Will the Automated Voice Response (AVR) system still be available after October 16, 2002?

Yes. Providers will be notified through Medicaid bulletins of AVR access changes and changes in the information that is available through AVR.

Remittance Advice

1. What is the difference between the electronic remittance advice (ERA) and the paper remittance advice (RA)?

The ERA consists of two transactions: the 835 claim payment/advice transaction and the 277 pending (unsolicitated) claim status transaction. These two transactions provide information on paid claims, adjusted claims, refunds, and pending claims payments. The ERA transactions and the 277 unsolicited claims status are intended to be used as an aid to account balancing and direct posting to patient accounts.

The paper RA also provides information on claims payment but includes a greater level of detail on claim denials. All providers will continue to receive the paper version of the RA, even if they choose to receive the ERA transactions.

ERAs in the tape format currently produced by N.C. Medicaid will be discontinued on October 16, 2003.

2. Will the EOB codes on the ERA be the same as the EOB codes on the paper RA?

N.C. Medicaid will implement the use of the standard Claims Adjustment Reason Code set, Remittance Remark Code set, Claim Status Category Code set, and Claim Status Code set for the ERA transactions as mandated by HIPAA. The EOBs currently used for paper RAs will not change. The AVR system will continue to provide explanations for paper EOB codes.

Claims Software Vendors and Clearinghouses

1. What is the process for providers who work with a clearinghouse?

The health care clearinghouse must comply with the standards outlined in the August 17, 2000 rule. There are additional requirements found in 45 CFR 162.923 (c) (1-2) and 45 CFR 162.930 that are specific to clearinghouses. Requirements for covered entities are outlined in 45 CFR 162.923. Providers will have the capability to submit and receive HIPAA compliant transactions when 1) N.C. Medicaid has the provider's certificate of compliancy from a third party certification agency on file or 2) the provider has successfully tested with N.C. Medicaid.

2. Will providers be held liable if their clearinghouse or billing agent is not compliant with the HIPAA transaction and code set standards regulation by October 16, 2003?

For questions regarding legal liability, please contact the Centers for Medicare and Medicaid Services (CMS). Their website is http://www.cms.gov.

3. Is N.C. Medicaid working with software companies and clearinghouses to ensure that they are HIPAA compliant? How will vendors and clearinghouses be notified of what changes are necessary?

It is the provider's responsibility to ensure that their software or clearinghouse is HIPAA compliant.

The X12N transaction HIPAA implementation guides are available on the Washington Publishing Company's website at http://www.wpc-edi.com. Consult the NCPDP website at http://www.ncpdp.org for the NCPDP transaction standards for retail pharmacy services.

4. What is a trading partner agreement and how does if effect me?

As defined in § 160.103 of the Transaction and Code Sets final rule, a trading partner agreement is defined as an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)

Providers who conduct electronic transactions with N.C. Medicaid will either need to enter a trading partner agreement directly with N.C. Medicaid or through their clearinghouse depending on how they submit electronic transactions. The trading partner agreement for N.C. Medicaid is currently under development. However, this agreement will contain, at a minimum, information regarding testing, what type of transactions will be exchanged, and protocol information for the exchange of those transactions.

5. When will testing with providers begin?

The projected time to begin testing directly with N.C. Medicaid is mid-February 2003. In lieu of testing directly with N.C. Medicaid, providers may test with a third party certification agency. Once certification information is on file with N.C. Medicaid, providers will have the capability to submit and receive HIPAA compliant transactions.

For more information regarding third party certification, please refer to the WEDI/SNIP Testing and Certification white paper at http://snip.wedi.org. Additional information will be provided in future Medicaid bulletins and on DMA's website at http://www.dhhs.state.nc.us/dma.

Summary of POS Changes

The North Carolina Medicaid POS system has gone through many changes in the past few months. The following summarizes the changes:

1. The POS system was upgraded to NCPDP 3.2 variable on April 15, 2002.

2. The early fill alert is now a hard edit and additional information is required to override the early fill. The process to override an early fill alert is to respond to the DUR alert and indicate one of the approved reason codes in the prescription clarification field (also referred to as the denial clarification field). The approved codes are as follows:

   03 – Vacation supply 04 – Lost prescription 05 – Therapy dosage change

   VACATION SUPPLY AND LOST PRESCRIPTION CODES ARE NOT ALLOWED ON CONTROLLED SUBSTANCES.

   Example of Early Fill Process:

   Once the pharmacist has verified with the patient the reason for the early fill, the following should occur. After receiving the alert the pharmacist will enter the following DUR override: CC = ER, IC = P0, OC = 1B. In addition, one of the reason codes listed above (03, 04 or 05) will need to be transcribed in the prescription clarification field. If any fields are left blank, the claim will deny.

   Actual Screen Print for Overriding Early Fill (using 05 as the reason code) and 6 Rx Limit

   Prior Auth./Medical Certification **5**
   Eligibility Clarification
   Prescription Denial Clarification **05**
   Conflict **ER** Intervention **P0** Outcome **1B**

3. The high-dose edit (Edit 907) has been changed; all quantities can now be overridden on the POS system once verified for accuracy. This edit uses the FDA guidelines to determine upper limit. To override this edit, place a "2" in the PA/MC field or the prescription denial clarification field.

   Example of High Dose Process:

   Once the pharmacist receives the message "Quantity dispensed is greater than recommended dose", the quantity and days supply should be verified. If correct, place a "2" in either the PA/MC field or the prescription denial clarification field.

4. Listed below are the current acceptable codes in the PA/MC field.

   "1" - PAMC- USED TO OVERRIDE THE MEDICARE EDIT *
   "2" - PAMC- SUPPLY-OVERRIDE
   "3" - PAMC- BOTH-SUPPLY-RXLIMIT (New: Both "2" and "5" are requested)
   (recommend using "5" PA/MC field and "2" in Rx Clarification field instead of the "3") **
   "4" - PAMC- COPAY-EXEMPT
   "5" - PAMC- RX-LIMIT-EXEMPT
   "8" - PAMC- BOTH-EXEMPT (combines both "4" and "5")
   "9" - PAMC- ALL-SUPPLY-COPAY-RXLIMIT (New: "2", "4" and "5" are requested)
   (recommend using "8" PA/MC field and "2" in Rx Clarification field instead of the "9") **

   ***** This override can be used to override the Medicare edit, when a drug is not covered by Medicare (the reason for non-coverage should be noted on the prescription).
   ******Note the recommended changes for values "3" and "9".

5. Pharmacy claims can now be billed online up to one year from the date of service.

6. Pharmacy claims with billed amounts up to $9,999.99 can now be billed online, excluding Synagis and Botox.

7. DAW 7 can now be used for Narrow Therapeutic Index drugs. This value will work the same as DAW 1, which overrides the MAC price.

8. Compounds can now be captured online using the compound NDC (00990-0000-00). This change will assist in the tracking of the prescription count. The claim will have to be submitted on paper or batch to receive payment.

9. The late refill alert was changed to an informational alert; overrides are no longer needed to fill the prescription.

10. POS hours have been extended. The hours are as follows:

- Monday 1:30 am - Midnight
- Tuesday 1:30 am - Midnight
- Wednesday 1:30 am - Midnight
- Thursday 1:30 am - Midnight
- Friday 6:00 am - Midnight
- Saturday 2:00 am - Midnight
- Sunday 6:00 am – Midnight

Days Supply on Prepackaged Hormone Replacement Therapy

Hormone replacement therapy packaged in 28-day supply dialpacks (i.e., Prempro, Premphase, etc.) can now be dispensed in quantities up to an 84-day supply. Only one dispensing fee will be paid and only one copay can be collected from the recipient.

34-Day Grace Period for Prescription Drug Prior Authorization

Effective May 1,2002, a 34-day grace period is available for obtaining prescription drug prior authorization (PA) for Medicaid recipients in nursing facilities, adult care homes, and intermediate care facilities for persons with mental retardation. A single 34-day grace period per prescription will be granted and applies to recipients already residing in these facilities as well as newly admitted recipients.

This grace period allows additional time to gather the medical information necessary to request PA from ACS State Healthcare, the contractor administering the Prescription Drug PA program. If ACS determines that the request does not meet the PA criteria, the prescriber may submit written justification for exemption according to the instructions outlined on page 10 of the July 2002 General Bulletin.

Changes to the Medicaid claims payment system will automate this 34-day grace period. Until these changes are finalized, it is imperative for the physician's office designee to contact ACS at 1-866-246-8505 (telephone) or 1-866-246-8507 (fax) to initiate the 34-day grace period. The caller must identify the patient as a resident of one of the long-term care facility types listed above and must provide the information requested on the top part of the Miscellaneous Drug Request form. The form can be obtained online at http://www.ncmedicaidpbm.com.

Long-Term Care Pharmacists May Seek Prescription Drug Prior Authorization

Effective May 1, 2002, pharmacists serving nursing facilities, adult care homes, and intermediate care facilities for persons with mental retardation are now allowed to request prior authorization (PA) for prescription drugs covered under Medicaid's Prescription Drug PA program. Previously, only the prescriber or prescriber's designee was authorized to make a PA request. The list of drugs requiring PA is available online at http://ww.ncmedicaidpbm.com.

North Carolina Medicaid Provider Services Help Desk

Provider Services is available from 8:30a.m. - 4:30 p.m. weekdays to answer general Medicaid pharmacy questions. They can be reached at 919-851-8888 or 1-800-688-6696. Calls between 4:30 p.m. to 5 p.m. weekdays should be directed to 919-233-6846.

All communication/technical POS problems should be directed to your "switch," especially NCPDP reject codes 99 for Host Processing Error.

Medicaid Credit Balance Report

Effective immediately, pharmacy providers can no longer submit Quarterly Medicaid Credit Balance Reports. All instances where credit is owed through adjustments to Medicaid must be handled through the on-line POS system.

Senior Care Drug Assistance Program

This fall, the North Carolina Health and Wellness Trust Fund Commission will begin implementing a senior prescription drug assistance and medication management program called Senior Care. The Senior Care program will be funded for three years. It is estimated that over 50,000 senior enrollees will receive assistance through the program. Senior Care will cover 60 percent of the first $1,000 of the cost of drugs needed for the treatment of COPD, cardiovascular disease or diabetes mellitus. The program employs an open formulary.

Applications are available at distribution points throughout the state such as senior center, departments of social services, departments of public health, hospitals, health centers, and pharmacies. Adults over the age of 65 residing in North Carolina who meet specific income criteria are eligible to apply for the Senior Care program. Senior adults who have other third party insurance coverage or are enrolled with Medicaid are not eligible to apply for Senior Care. Seniors who apply and are deemed eligible can begin using their Senior Care card on November 1, 2002.

Senior Care has contracted with ACS to serve as the pharmacy benefit manager for the program. ACS will process enrollment applications, pay claims, contract with pharmacies, and provide customer service. ACS is currently in the process of contracting with pharmacies throughout the state to participate in their network for Senior Care.

Pharmacists can contact at ACS at 1-866-226-1388.

Synagis® / RespiGam® Prior Authorization for RSV Prophylaxis

Prior Approval Process

Patient must be in one of the following groups:

a. Infants < 24 months of age at the start of RSV season with chronic lung disease (CLD) that necessitated treatment in the last 6 months **OR**

b. Neonates who were born between 28 weeks and 32 weeks gestation without CLD who are < 6 months of age at the start of RSV season **OR**

c. Neonates born at 28 weeks gestation or less without CLD and who are <12 months of age at the start of the RSV season **OR**

d. Neonates born between 32 and 35 weeks gestation without CLD who are < 6 months at the start of the RSV season and who have other medical illnesses and other risk factors (≥ 2) that predispose to respiratory complications such as siblings attending school, day-care attendance, exposure to cigarette smoke in home, multiple births, anticipated cardiac surgery, distance to and availability of hospital care for severe respiratory illness **AND**

2. Must be used for prevention, not treatment of RSV.

3. Acyanotic congenital heart disease is not a contraindication

4. The drug is approved for administration once monthly up to six doses during RSV season (as determined by yearly CDC guidelines but generally November through April).

5. The physician must give the following information and provide it as well in his or her own handwriting across the face of the prescription the date of birth of the patient, gestational age at birth, and current weight.

6. The request must be made from the physician's office so that any discussions needed with the physician can be expedited.

References:

1. **1.** Committee on Infectious Disease and Committee on Fetus and Newborn. Prevention of respiratory syncytial virus infections: Indications for the use of palivizumab and update on the use of RSV-IGIV. Pediatrics 1998;102:1211-1216.

Billing Instructions

All claims for Synagis® should be submitted either by batch or on a manual claim form to EDS. If the patient requires 150mg of Synagis®, then the claim should be billed like a compound. This should be broken down into a claim for the 100mg vial and the 50mg vial. The same RX number should be used for both claims and the compound indicator placed in the EPSDT field. If there were no other compounds for the month, the compound indicator would be "A" for both claims. This method of billing will treat the claim as one prescription, so that only one dispensing fee is paid.

North Carolina Medicaid

Synagis® / RespiGam® Prior Authorization for RSV Prophylaxis

Request Date _____

Recipient's Medicaid ID# _____

Recipient's Full Name_____

Prescriber's Full Name _____ Prescriber's DEA # _____

Prescriber's Address (mandatory) _____

_____

City _____ State _____ Zip _____

_____

Prescriber's Telephone # _____ Prescriber's Fax #_____

Prescriber E-mail Address

_____

RSV prophylaxis with Synagis® or RespiGam® should be initiated one month before or at onset of the RSV season and terminated at the end of the RSV season. The RSV season typically begins in November and ends in March to April. No more than 6 doses will be approved for the 2002-03 RSV prophylaxis season. The recommended dose of Synagis® is 15 mg/kg of body weight, given once a month during RSV season. Synagis® is supplied in either a 100 mg vial or 50 mg vial. For RespiGam product information, please refer to product labeling. The request for these drugs must be made from the physician's office directly; the request should include the specific reasons for prophylaxis in children who fall into category 1d. This will expedite approval.

1. What is the **diagnosis or indication** for use of the product for prophylaxis? Please check one of the categories below.
   - ❑ 1-a Infant < 24 months of age at the start of RSV season **with** Chronic Lung Disease (CLD) that has necessitated treatment in the last 6 months.
   - ❑ 1-bNeonate born between 28 and 32 weeks gestation **without** Chronic Lung Disease (CLD) who is < 6 months of age at the start of RSV season.
   - ❑ 1-c: Neonate born at 28 weeks gestation or less **without** Chronic Lung Disease (CLD) who is < 12 months old at the start of RSV season.
   - ❑ 1-d: Neonate born between 32 and 35 weeks of gestation **without** Chronic Lung Disease (CLD) who have other medical illnesses who are less than 6 months old at the start of the RSV season and who have other risk factors (two or more) that predispose to respiratory complications.

     Other medical illness _____

     Other risk factors - Check **all** that apply.
     - ❑ Recipient has sibling(s) that attend school
     - ❑ Recipient attends day-care
     - ❑ Recipient has exposure to cigarette smoke in home
     - ❑ Recipient was part of multiple baby birth (e.g., twin, triplet)
     - ❑ Recipient is anticipated to have cardiac surgery for acyanotic heart disease
     - ❑ Other risk factor(s)_____

ACS Use Only

( ) Preliminary Approval Category 1-d

( ) Preliminary Denial Category 1-d

2. Additional recipient information. It should be noted that this information must also be handwritten by the physician on the face of the prescription:

Date of birth_____

Gestational age at birth (in weeks) _____

Current Weight (in kg)_____

3. Dose requested*_____

- ❑ Synagis® 50mg vial(s)_____Synagis® 100 mg vial(s)_____
- ❑ RespiGam®_____

4. Date(s) requested*

a. Starting date_____

b. Ending date_____

Instructions to physician on how to submit: (Choose one)

To Fax or Mail:

1. Form may be completed electronically or hand written.
2. Fax or mail to ACS State Healthcare.

To Email:

1. Save the form using a different filename.
2. Complete electronically.
3. E-mail as an attachment to ACS State Healthcare.

Send to:
ACS State Healthcare, Prescription Benefits management
Prior Authorization Dept.
Northridge Center One, Suite 400
365 Northridge Road
Atlanta, GA 30350

Fax: (866) 246-8507

E-Mail: nc.providerrelationss@acs-inc.com

Questions - Phone: (866) 246-8505; M-F 7am-11pm, EST; S-S 7am-6pm

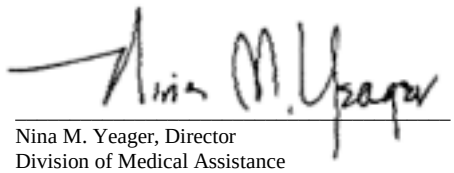
Checkwrite Schedule

October 8, 2002	November 5, 2002	December 10, 2002
October 15, 2002	November 13, 2002	December 17, 2002
October 22, 2002	November 19, 2002	December 27, 2002
October 30, 2002	November 26, 2002	

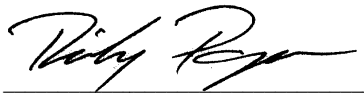
Electronic Cut-Off Schedule

October 4, 2002	November 1, 2002	December 6, 2002
October 11, 2002	November 8, 2002	December 13, 2002
October 18, 2002	November 15, 2002	December 20, 2002
October 25, 2002	November 22, 2002	

Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date.



Nina M. Yeager, Director
Division of Medical Assistance
Department of Health and Human Services



Ricky Pope
Executive Director
EDS

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P.O. Box 300001
Raleigh, North Carolina 27622

Presorted Standard
U.S. POSTAGE
PAID
Raleigh, N.C.
Permit No. 1087